TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
GILBERT GONZALES, DC

MFDR Tracking Number
M4-20-1257-01

MFDR Date Received
January 21, 2020

Respondent Name
GREAT MIDWEST INSURANCE COMPANY

Carrier's Austin Representative
Box Number 19

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Does not indicate range of motion testing requires PreAuth."

Amount in Dispute: $960.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…since it appears that the provider failed to file a request for reconsideration, it is premature for the provider to file a request for Medical Fee Dispute Resolution under Division rule 133.307. In fact, the Division should dismiss the provider's request for Medical Fee Dispute Resolution because the medical bill in dispute has not been submitted to the insurance carrier for an appeal."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
April 9, 2019	95831, 95832 and 95851	$960.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code (TLC) §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Title 28, Part 2, Chapter 133, Subchapter D, Rule §133.307 sets out the administrative requirements for filing of a medical fee dispute.
2. Title 28, Part 2, Chapter 133, Subchapter C, Rule §133.250 sets out the requirement for reconsideration prior to filing for medical fee dispute resolution.

Findings

The medical fee dispute resolution program resolves disputes over payment of medical bills. Health care providers are responsible for taking certain actions **before** filing medical fee dispute resolution. These actions include, but are not limited to: (1) billing the carrier for the services; (2) asking the carrier for reconsideration of the final action taken by the carrier on the originally filed medical bills; and (4) allowing the carrier 30 days to respond to the request for reconsideration.[1] The requestor has the burden to prove that it took these actions before filing for medical fee dispute resolution.

The Division now reviews the information and documentation provided by requestors, to determine whether this fee dispute is ripe for medical fee dispute resolution review.

The requirement for health care providers to seek reconsideration of a medical bill **before** filing for fee dispute resolution is found at 28 Texas Administrative Code (TAC) §133.250 which states, in pertinent part, that if the health care provider is dissatisfied with the insurance carrier's final action on a medical bill **after reconsideration**, the health care provider may then request medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills). Nexus Health Systems has failed to meet its burden to prove that it sought reconsideration for the services in dispute prior to filing this medical fee dispute. Absent any evidence from the requestor that reconsideration was sought, the Division finds that these services are not eligible for review.

Conclusion

For the reasons stated above, the Division finds that the requestor has not met the requirements for filing a medical fee dispute. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to TLC Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 21, 2020 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 TAC §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** form **DWC045M** in accordance with the instructions on the form. The request must be received by the DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

Si prefiere habl ar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

[1] 28 TAC §133.250 (j) If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills).